

EXHIBIT F

South Jersey Healthcare
Changing Medicine. Changing Lives.

PATIENT INFORMATION SHEET

PAT: **CATLETT, AMY**
3137 SWAN DR

VINELAND, NJ 08361

H: **856-692-0938**

W:

MOA: **Walk In**

* * * * * PRIVACY IND * * * * *

GUAR: **CATLETT, AMY**
3137 SWAN DR

VINELAND, NJ 08361

MED REC: **900038941**

DOB: **02/06/1973**

SEX: **F**

AGE: **36Y**

MATSTAT: **S**

ECD: **75282352**

ADM: **11/21/2009 21:24**

EMPLOYER:

PRIM. LANG: **English**

ENCOUNTER: **4360872**

GUAR EMP: **RONE, HUGHS, KOWALSKI**
37 CANNON RANGE RD

MILMAY, NJ 08340

PT IS THE: **S**

EMR: **ZIELINSKI, MARSHA**
CNTCT1: **3137 SWAN DR**
VINELAND, NJ 08360
856-692-0938

EMR:
CNTCT2:

PT IS THE: **Child**

PT IS THE:

I1. **Self-Pay No Ins**
SJH-Patient Billing Services
333 Irving Avenue
Bridgeton NJ 08302

PH:

GRP#:
SUB: **CATLETT, AMY**
POL#: **900038941**
TAR#:

EFF DT: **//**
ESP DT: **//**
DOB: **//**
PT IS THE:

I2:

GRP#:
SUB: **,**
POL#:
TAR#:

EFF DT: **//**
EXP DT: **//**
DOB: **//**
PT IS THE:

PH:

I3:

GRP#:
SUB: **,**
POL#:
TAR#:

EFF DT: **//**
EXP DT: **//**
DOB: **//**
PT IS THE:

PH:

I4:

GRP#:
SUB: **,**
POL#:
TAR#:

EFF DT: **//**
EXP DT: **//**
DOB: **//**
PT IS THE:

PH:

ADM PHY: **KASPER, LAURA**
REF PHY: **,**
ACDNT DT: **//**

ATT PHY:
FAM PHY:

KASPER, LAURA

ADM DIAG/CHIEF COMP/REASON: **TRANS FROM RMC CRISIS EVAL**

ADV DIR: **Patient has No Living Will**

DIAGNOSIS:

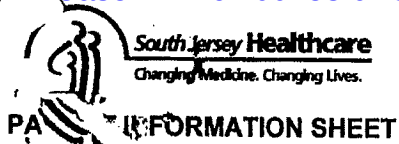
SJH - DIV: **B Emergency Room Services**

ADM SOURCE: **EO**

- PATIENT: **CATLETT, AMY**
- UNIT / RM-BED:
- MED REC NO: **900038941**
ENCOUNTER: **4360872**
-ECD NO: **75282352**

SVC: **EMR**
PT: **ER**

REG INIT: **U0AE_cald6664**



Acct# 75282256MRN 941 11/21/2009
CATLETT, AMY
 DOB 02/06/1973 Sex F Age 36Y
 ATT DR: DIORIO, DOMINIC



PATIENT INFORMATION SHEET

PAT: **CATLETT, AMY**
3137 SWAN DR

VINELAND, NJ 08360

H: **215-299-4295**

W:

MOA: **Walk In**

***** PRIVACY IND *****

GUAR: **CATLETT, AMY**
3137 SWAN DR

VINELAND, NJ 08360

PT IS THE: **S**

EMR:
 CNTCT1:

EMR:
 CNTCT2:

MED REC: **285646455**

ADM: **11/21/2009 16:17**

DOB: **06/06/1973**

EMPLOYER:

SEX: **F**

PRIM. LANG: **English**

AGE: **36Y**

MATSTAT: **S**

ECD: **75282265**

ENCOUNTER: **4360773**

GUAR EMP:

Rone Hughes Kowski

PT IS THE:

PT IS THE:

I1. **Self-Pay No Ins**
SJH-Patient Billing Services
333 Irving Avenue
Bridgeton NJ 08302
 PH:

GRP#:
 SUB: **CATLETT, AMY**
 POL#: **285646455**
 TAR#:

EFF DT: //
 ESP DT: //
 DOB: //
 PT IS THE:

I2:

GRP#:
 SUB: ,
 POL#:
 TAR#:

EFF DT: //
 EXP DT: //
 DOB: //
 PT IS THE:

PH:

I3:

GRP#:
 SUB: ,
 POL#:
 TAR#:

EFF DT: //
 EXP DT: //
 DOB: //
 PT IS THE:

PH:

I4:

GRP#:
 SUB: ,
 POL#:
 TAR#:

EFF DT: //
 EXP DT: //
 DOB: //
 PT IS THE:

PH:

ADM PHY: **DIORIO, DOMINIC**
 REF PHY: ,
 ACDNT DT: //

ATT PHY:
 FAM PHY:

DIORIO, DOMINIC

A Heck-Gary

ADM DIAG/CHIEF COMP/REASON: **EVAL**

ADV DIR: **Patient has No Living Will**

DIAGNOSIS:

SJH - DIV: **R Emergency Room**

ADM SOURCE: **EO**

- PATIENT: **CATLETT, AMY**
 - UNIT / RM-BED:
 - MED REC NO: **285646455**
 - ENCOUNTER: **4360773**
 - ECD NO: **75282265**

SVC: **EMR**
 PT: **ER**

REG INIT: **U0AE_pier7780**

SOUTH JERSEY HEALTHCARE / OTHER HOSPITAL BASED SPECIALTY GROUPS

☐ BRIDGETON☐ ELMER☐ REGIONAL MEDICAL CENTERPATIENT NAME: **CATLETT, AMY**ACCT # **75282265**DATE OF SERVICE: **11/21/2009**

I, the undersigned hereby agree: To grant consent to the physicians / hospital personnel to administer any treatment or medication as may be deemed necessary and / or advisable in the diagnosis and / or treatment of the above named patient.

In consideration of the services to be rendered to the above patient to pay the account of the hospital in accordance with the regular rates and terms of the hospital. I understand that giving insurance information does not relieve me of the responsibility to this claim. I further understand that it is my responsibility to resolve any disputes with my insurance company for non-payment after SJH / other Hospital Based Specialty Groups submits the initial bill. I understand that I will be charged for all costs should it be necessary for SJH / other Hospital Based Specialty Groups to employ the services of an attorney or collection agency to resolve this claim.

YES NO

- ☒ ☐ Authorize payment directly to SJH / other Hospital Based Specialty Groups of any hospital / medical benefits (do not exceed the hospital's / physician's normal charge) otherwise payable to me for the period of hospitalization shown above. I understand that this authorization does not release me of the responsibility for this claim and for any balance that may not be covered by my insurance.
- ☒ ☐ PHYSICIANS
I understand that I will receive separate bills from the hospital and any / all physicians involved with this visit.
- ☒ ☐ I have received and understand my "Patient Rights."
- ☒ ☐ At this time or earlier, I have received a copy of the Hospital's Privacy Notice.
- ☒ ☐ I authorize SJH / other Hospital Based Specialty Groups and/or its associated physicians, to release information about my insurance coverage and the treatment provided to me to any person or entity who provides me with health care services that are related to this admission or outpatient treatment or who is involved in the payment for those health care services. I also authorize SJH / other Hospital Based Specialty Groups and/or its associated physicians, to release information about the treatment provided to me to any facility or individual who has a need to know that information in order to provide me with on-going treatment. This authorization is only valid until my medical claims have been resolved.
- ☒ ☐ I have received information regarding Medication Assistance Program and hereby appoint Pharmacy Healthcare Solutions of SJH Limited Power of Attorney to apply on my behalf and obtain replacement/reimbursement of my medications from pharmaceutical manufactures.
- ☒ ☐ I have received information about SJH Healthy Communities Education on Smoking Cessation. I agree to comply with the Inpatient Non-smoking Policy.
- ☒ ☐ I have received information regarding Personal Property and release SJH of all liability for loss, theft or damage to property not placed in the hospital safe.
- ☒ ☐ I authorize SJH to include my name, location in the Hospital, general health condition, and religious affiliation in a Patient Directory. Such information that the Hospital includes in its directory, may be disclosed to anyone who asks for me by name or members of the clergy; provided however, that religious affiliation will only be disclosed to members of clergy. If I do not want this information included in the patient directory I must so inform the Hospital upon admission, or at any time during my Hospital admission.
- ☒ ☐ I authorize SJH to disclose Patient Health Information to my family members and to other persons when that Patient Health Information is directly relevant to that person's involvement in my health care or payment. I understand that I may ask the Hospital to consider restricting these disclosures.
- ☐ ☐ I certify that I have No Automobile Insurance. I further Certify that no one living in my immediate household has automobile insurance.
- ☒ ☐ MEDICAID Patients Certification / Authorization
I certify that the services covered by this claim have been received, and I request that payment for these services be made on my behalf to SJH / other Hospital Based Specialty Groups and / or its associated physicians. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents, any information needed for this or a related claim.
- ☒ ☐ MEDICARE Patients Certification / Authorization
I certify that the information given by me in applying for payment under Title xviii of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and / or the Medicare Program or its intermediaries, carriers or to Professional Standards Review Organizations any information needed for this or a related Medicare claim. I further request that payment of authorized benefits be made on my behalf to SJH / other Based Specialty Groups and / or its associated physicians.
- ☐ ☐ I certify that I have received a copy of "An Important Message From Medicare".
- ☐ ☐ CHAMPUS Certification I certify that I have received a copy of "An Important Message from Champus".
- ☐ ☐ I have received information about Financial Assistance Programs.

I certify that I have read and understand the above information and that all listed items have been marked with my authorization.

Patient / Authorized Signature

Witness Signature

Date

☐ self ☐ guardian ☐ _____



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Acct# 75282256MRN 941

11/21/2009

CATLETT, AMY

DOB 02/06/1973 Sex F

Age 36Y

Name: CATLETT, AMY

Phone #:

DOB: 02/06/1973

Date: 11/21/2009

Time of Arrival: 15:52

MOA: ☐ Walk ☐ WC ☐ EMS ☐ Carry

Age: 36Y

Primary Doctor:

Work Related: ☐ Yes ☒ No — If Yes, Post Accident Testing: ☐ Yes ☒ No — OHS paged at:

Triage Time:

Current Medications/Allergies — See Medication Reconciliation form

Treatment Prior to Arrival:

Chief Complaint / Hx of Illness/Injury: EDP ANXIETY

had suicidal thoughts "Mr. Let-Cat" someone would put her in a cage for the rest of the year" "I don't even have thoughts about hurting myself"

V P U
☒ AA/Ox3 ☐ Denies LOC
☐ Age Appropriate

Vital Signs: T: (p, r, ax)

BP: 152/80 P: 116

R: 20 SaO2: 100%

Past Hx: (check all that apply) ☐ Asthma ☐ CHF ☐ CAD ☐ COPD☐ DM ☐ TB ☐ Seizures ☐ HTN ☐ Thyroid ☐ Stroke ☐ MI☐ ↑ Cholesterol ☒ Psych Hx:☐ CA type:☐ Surgical Hx:☐ Other:Visual Acuity: ☒ N/A Corrective Lenses: ☐ Yes ☐ No☐ Right Eye:☐ Left Eye:

Immunizations: Childhood: ☒ DTD ☐ NUTD
Tetanus: Last known date ☐ N/A ☒ Unknown

PPD: ☐ Positive ☐ Negative ☐ Unknown

Flu Vaccine: Last known date

☐ No ☐ Unknown

Pneumovax (over 65 yrs) Last known date

☐ No ☐ Unknown

Fall Risk Screen: *Apply a yellow arm bracelet & initiate fall risk safety interventions if any of the following criteria are met:

☐ Physical impairment☐ Cognitive impairment☐ History of falls☐ Current medications

Fall Risk Safety Interventions:

☐ Stretcher/WC wheels locked☐ Stretcher side rails up x 2☐ Family members at patient side☐ Patient door/curtain openESI CATEGORY: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Triage RN Signature:

Time to Treatment Area:

(print name):

ED NURSING ASSESSMENT (Check all that apply)

Neuro: A V P U ☒ AA/Ox3 ☐ Age Appropriate
☐ See GCS Scale ☒ See Dysphagia Screen

Psycho-Social Hx: ☐ Tobacco ☐ ETOH ☐ Drugs
☐ Social Worker Notified ☐ Crisis Counselor Notified — Time:
☐ No Problems Identified ☒ Problems Identified (Describe):

Skin: ☒ Normal, Warm & Dry ☐ Hot, Febrile ☐ Cool
☐ Diaphoretic ☐ Pale ☐ Flush ☐ Cyanotic ☐ Jaundice
☐ Wounds/Burns ☐ Rash ☐ Pressure Ulcer (Describe):

Respiratory:

☒ Normal ☐ Deep ☐ Shallow ☐ Apnea ☐ Dyspnea

Airway: ☐ Patent ☐ Obstructed ☐ Nasal Flaring ☐ Stridor
☐ Exp. Grunt ☐ Retraction ☐ Intubation

Cough: ☐ Non-Productive ☐ Productive — Color:

Breath Sounds: ☐ Normal Clear ☐ Decreased ☐ Rales
☐ Wheezing ☐ Rhonchi ☐ Absent R: ↑ ↓ L: ↑ ↓

Cardiovascular:

Apical: ☐ Regular ☐ Irregular Cap. Refill: sec.

Radial: L R Dorsalis Pedis: L R

Chest Pain: ☐ Yes ☐ No Complaint Edema: ☐ N/A L R

Onset:

Radiation:

Description:

Monitor Rhythm:

Valuables Secured: ☐ Patient ☐ Security

Locker #

☐ Safe ☐ Family

Initial Assessment RN Signature:

(print name):

Time:

GI:

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation☐ Incontinent Stool Last BM:Appetite: ☐ Good ☐ PoorBowel Sounds: ☐ Present ☐ Absent ☐ Hypo ☐ HyperAbdomen: ☐ Normal ☐ Distended ☐ Rigid☐ Guarded ☐ Rebound ☐ TenderGU: ☐ Flank Pain ☐ Dysuria ☐ Hematuria☐ Frequency ☐ Incontinent ☐ Penile Discharge ☐ Foley

GYN/OB:

Pregnant: ☐ Yes ☐ No G P AB

LMP FHR EDC

☐ Bleeding ☐ Discharge ☐ Menopause☐ Hysterectomy ☐ Tubal Ligation — Date:

Musculoskeletal:

☐ Pain ☐ Weakness ☐ Paralysis

Extremity: Location of Injury:

Appearance: ☐ Normal ☐ Red ☐ Pale ☐ Dusky☐ Mottled ☐ SwollenSensation: ☐ Full ☐ Decreased ☐ Absent

Circulation: Cap. Refill: sec.

☐ Peripheral Pulses PresentMovement: ☐ Full ROM ☐ Partial ROM ☐ NoneSpeech: ☐ Normal ☐ Slurred ☐ Incoherent ☐ Aphasic☐ Language Barrier ☐ Age Appropriate

Age36Y

02/06/1973 75282256



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Acct# 75282256MRN 941

11/21/2009

CATLETT, AMY

DOB 02/06/1973

Sex F

Age 36Y



EMERGENCY PHYSICIAN RECORD

DATA REVIEWED:

- ☐ VS / Triage Assessment ☐ Transfer Sheet
☐ EMS record ☐ Meds / Med Rec form
☐ Prev. ER record ☐ Prev. inpatient chart

HISTORY per: ☒ Patient ☐ Family ☐ EMS ☐ Interpreter
☐ Other:

☐ Pt required immediate critical intervention
☐ Pt unable to provide Hx (reason):

Chief Complaint / HPI: Onset, Location, Quality, Severity, Duration, Timing, Context, Associate Sxs, Modifying Factors
Time Seen: 10:35

36 y/o female diagnosed by VPD - Pt allegedly made statements on jail bond that triggered a call to police. PM called tried me Pt stated "she wished someone would put her in a coma" - Pt non cooperative

PAST HISTORY: ☐ Per Triage ☐ None ☐ Asthma ☐ DM ☐ CA (type): ☐ CHF ☐ CAD ☐ COPD ☐ HTN
☐ Seizures ☐ TB ☐ Psych Surg Hx: Other:

Social History: ☐ Per Nursing Assessment ☐ Tobacco ☐ ETOH ☐ Drugs Lives with/at
☐ Problems Identified (Describe):

Family History: ☐ No significant FH ☐ Asthma ☐ DM ☐ CAD ☐ HTN Other:

Review of Systems: ☐ See Nurses Notes

CONSTITUTIONAL: ☐ Malaise ☐ Fever ☐ Chills

ENT: ☐ Sore Throat ☐ Ear Pain ☐ Rinorrhea ☐ Congestion

EYES: ☐ Vision Change ☐ Eye Pain ☐ Photophobia

PULMONARY: ☐ Cough ☐ SOB ☐ Hemoptysis

CARDIAC: ☐ Palpitations ☐ Chest Pain ☐ Orthopnea

ENDOCRINE: ☐ Polydipsia ☐ Polyuria ☐ Weight Change

GI: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Blood in Stool

GU: ☐ Dysuria ☐ Frequency ☐ Hematuria ☐ Discharge

HEMA/LYMPH: ☐ Bleeding ☐ Bruising ☐ Swollen glands

NEURO: ☐ Extremity weakness ☐ Dizziness ☐ Headache

SKIN: ☐ Rash ☐ Pruritis ☐ Diaphoresis ☐ Abrasion

PSYCH: ☐ Anxiety ☐ Depression ☐ Suicidal thoughts ☐ Dangerous behavior

SKELETAL EXT: ☐ Swelling ☐ Arthralgia ☐ Myalgia Hand dominance: ☐ Right ☐ Left

☐ All Other Systems Negative ☐ UTO - (Reason):

EXAM: Temp Pulse Resp BP / Pulse Ox % ☐ hypoxic ☐ non-hypoxic
GENERAL: ☒ Well Developed ☒ Well Nourished Physical Distress: ☐ None Apparent ☐ Mild ☐ Moderate ☐ Severe

ENT: ☐ Hearing Grossly Intact Membranes: ☒ Pink ☒ Moist ☐ No Stridor

EYES: ☐ Vision Grossly Normal ☐ No Icterus ☒ No Papilledema

NECK: ☒ Supple ☒ Trachea Midline ☒ No JVD ☒ No Bruits ☒ No Thyromegaly

SKIN: ☐ No Diaphoresis ☐ No Rash ☐ No Jaundice

HEART: ☒ RRR ☐ No Murmur ☒ No Gallup ☐ No Rub ☐ No Reproducible Tenderness

LUNGS: ☒ CTA ☒ Equal ☐ No Wheezes ☐ No Rales ☐ No Rhonchi

ABD: ☐ BS ☒ Soft ☐ Non-tender ☐ No Masses ☐ No Megaly

GU: ☐ Grossly Normal External Genitalia ☐ No CVA tenderness

PELVIC: Vag: ☐ No Blood ☐ No Discharge

Cervix: ☐ No Lesions ☐ No CMT ☐ No Discharge Os: ☐ Closed

Uterus: ☐ Normal Size ☐ Normal Contour Adnexa: ☐ No mass ☐ No Tenderness

RECTAL: ☐ Heme Neg ☐ Tone Normal ☐ No Mass

NEUROLOGIC: ☒ Alert ☐ Nonfocal ☒ Oriented x 3 GCS Score 15

MUSCULOSKELETAL: Ext: ☐ FROM ☒ No Deformities ☐ N/V Intact

Back: ☐ No tenderness ☒ FROM

Neck: ☐ No tenderness ☒ FROM

HEMATOLOGIC/IMMUNOLOGIC: ☐ No Adenopathy ☐ No petechia

PSYCHIATRIC: Affect: ☐ Flat ☐ Normal ☐ Nonverbal ☐ Agitated Judgment: Mood:

Physician Signature:

Print Name:

Date:

Time:

Age36Y



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**EMERGENCY ROOM REPORT
CONTINUATION SHEET**

Acct# 75282256MRN 941

CATLETT, AMY

DOB 02/06/1973

Sex F

ATT DR: DIORIO, DOMINIC

11/21/2009

Age 36Y



Patient Number

Patient's Last Name

Patient's First Name

Date

Date/Time Physician Notes

Date/Time Nurses Notes

11/21/09 (1720 cont'd) VPD officer stating he knows pt personally. Pt advised that nurse is per order not to draw pt for post exposure & requesting her cooperation. Pt still refusing lab draw. At 1730 nurse speak to again. (1805) Phlebs attempted lab draw again, per Dr. Terrigno pt is willing, pt again refused. Nursing supervisor advised & will call hospital atty. (1835) Mr. Shawn Brown, supervisor, made public comment indicating SI and therefore cannot refuse to have blood drawn. (1845) Labs drawn & sent. Pt state she "is going to sue" for lab draws. mother & 5/5 c pt; pt cooperative at this time. (1900) Report to morning shift.

(1905) Rec'd pt from ER. Pt agitation "Doesn't understand why here". RD explained why pt here and process & protocol at ER. Pt OK. Pt OK lungs clear. Pt on O2. Vitals per flow sheet. Pt is 4'10" in 4' quad and soft nontender. Pt asked for urine specimen. Pt uncooperative. Pt's family at bedside. (1915) Pt ran out ER to parking lot. Pt ignored order to come back. Security aware and proceeding after patient in

PHYSICIAN'S SIGNATURE

DATE

NURSE'S SIGNATURE

DATE



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EMERGENCY ROOM REPORT CONTINUATION SHEET

Acct# 75282256MRN 941
CATLETT, AMY
DOB 02/06/1973 Sex F
ATT DR: DIORIO, DOMINIC

11/21/2009
Age 36Y



Patient Number

Patient's Last Name

Patient's First Name

Date

Date/Time Physician Notes

11/21/09

parking lot - ms 1625 Pt brought back to ER to RM4. A trying to free self from security. Attempting to hit and kick security. A restrained as ordered - ms 1630 Pt told we need urine specimen. A screaming no. A told again of process for transfer to Bridgeton crisis. A told of labs and urine required to clear pt. Straight cath procedure explained to patient. Pt agreed to give urine specimen. Urine sent to lab. Family asked to wait in lobby. A ~~will~~ will keep family informed of pt's condition - L (2040) Report called to Bridgeton Crisis. Spoke to Shanna RN. Pt restraints now off. Pt tearing but now cooperative. Pt transferred to Bridgeton Crisis & MRS. Security to take valuables to Bridgeton. - L

Date/Time Nurses Notes

In lobby. A ~~will~~ will keep family informed of pt's condition - L (2040) Report called to Bridgeton Crisis. Spoke to Shanna RN. Pt restraints now off. Pt tearing but now cooperative. Pt transferred to Bridgeton Crisis & MRS. Security to take valuables to Bridgeton. - L

PHYSICIAN'S SIGNATURE

DATE

NURSE'S SIGNATURE

DATE

[Handwritten Signature]

11/21/09



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EMERGENCY ROOM REPORT CONTINUATION SHEET

Acct# 75282256MRN 941
CATLETT, AMY
DOB 02/06/1973 Sex F
ATT DR: DIORIO, DOMINIC

11/21/2009

Age 36Y



Patient Number

Patient's Last Name

Patient's First Name

Date

Date/Time Physician Notes

11-21-9

9:00 PM Pt cleared by Dr. Bill Martin at SJHS-Rmc
and transferred to Bridgeton crisis for
crisis eval. Transport uneventful.
11:00 PM Pt evaluated by crisis and discharged
per Dr. Panah - Psychiatrist.

Date/Time Nurses Notes

[Signature]

9 PM CH placed on gait belt brought to ER
via Millville Rescue
1986 87 R22 B1 15/86
10:00 AM Crisis prepared initiated
11:00 AM Collateral completed
11:30 AM Case discussed with Dr. Panah
11:55 AM CH ambulatory per ER & Mother, per
&quest. Value returned

Physician's Signature

Date


Nurse's Signature

Date

SJH-1082A-1



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Acct# 75282256MRN 941 11/21/2009
CATLETT, AMY
 DOB 02/08/1973 Sex F Age 36Y
 ATT DR: DIORIO, DOMINIC


EMERGENCY ROOM REPORT CONTINUATION SHEET

| | | | |
|---------------------------|---------------------|----------------------|------|
| Patient Number | Patient's Last Name | Patient's First Name | Date |
| Date/Time Physician Notes | | | |

Date/Time Nurses Notes

6:130 11/21/09 rec'd pt C1. AROX Speech
 clear. calm, behavior cooperative. Denies
 SI/HT. Awaiting eval from crisis (26)

Physician's Signature

Date

SJH-1062A-1

Nurse's Signature

Date



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EMERGENCY ROOM REPORT CONTINUATION SHEET

Acct# 75282256MRN 941
CATLETT, AMY
DOB 02/06/1973 Sex F
ATT DR: DIORIO, DOMINIC

11/21/2009

Age 36Y

| DATE: | | NURSES RECORD (continued) PAGE # | | | | | |
|-------|--------------|----------------------------------|------|------|------|----|------|
| TIME | IV Sol / Add | Amt | Site | Rate | Size | DC | Init |
| | | | | | | | |
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| DATE: | | Med / Dose & Response | | | | Route | PIS | Time | Init |
|-------|-----------|-----------------------|--|--|--|-------|-----|------|------|
| 1. | Response: | | | | | | | | |
| 2. | Response: | | | | | | | | |
| 3. | Response: | | | | | | | | |
| 4. | Response: | | | | | | | | |
| 5. | Response: | | | | | | | | |

| DATE: | | TIME | T | P | R | BP | SaO2 | Monitor |
|-------|--|-------|-----|----|----|--------|---------|---------|
| | | 21:00 | 98% | 93 | 18 | 143/80 | 100% RA | |
| | | | | | | | | |
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| GLASGOW COMA SCALE | | | | | | | | | | |
|--------------------|--------|----------|-------------|-----------------|----------------|------------|----------|-------------|--|---|
| TIME | Pupils | | Neuro | | | Movement | | TOTAL SCORE | PUPIL RESPONSE TO BRIGHT LIGHT Normal-N Sluggish-S Fixed-F EYE OPENING Spontaneous-4 To Voice-3 To Pain-2 None-1 MOVEMENT Strong-S Weak-W None-N | VERBAL RESPONSE Oriented-5 Confused-4 Inappropriate-3 Incomprehensible-2 None-1 MOTOR RESPONSE Obeys Command-6 Localizes Pain-5 Withdrawals (Pain)-4 Flexion (Pain)-3 Extension (Pain)-2 None-1 |
| | Size | Response | Eye Opening | Verbal Response | Motor Response | Hand Grasp | Leg Mvmt | | | |
| | R | L | | | | R | L | | | |
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| Nurse Signature | Print Name | Initials |
|-----------------------------|---------------|----------|
| <i>Shanna J. Grover, RN</i> | S. Grover, RN | AG |



South Jersey Healthcare®
Changing Medicine. Changing Lives.

Acct# 75282256MRN 941
CATLETT, AMY
DOB 02/06/1973 Sex F
ATT DR: DIORIO, DOMINIC

11/21/2009
Age 36Y

RESTRAINT ORDER FORM

Date Ordered: 11/21/09 Time Ordered: 1645
Time Restraints Applied: 1645

Type of Restraint: Hand Mitt Soft Extremity Vest Body Net Seclusion Locked Velcro Safety Bed 4 Siderails
Number of Extremities: (L) Hand (R) Hand (L) Arm (R) Arm (L) Leg (R) Leg
Interventions Attempted (Circle all that apply)

| | |
|------------------------------------|--------------------------|
| <u>C/S</u> Companion/Supervise | MED Medication Review |
| <u>CM</u> Comfort Measures | RE Reposition |
| <u>ENV</u> Modify Environment | PD Postural Device |
| <u>RO</u> Reality Orientation | S Snacks |
| <u>DIV</u> Diversion Activities | VI 1:1 Verbal |
| <u>CALL</u> Call Light in Reach | PA Physical Reassessment |
| <u>B/B</u> Bowel Bladder Regime | O Other |
| <u>MP</u> Move Pt Close to Station | FP Fall Precautions |
| <u>EX</u> Exercise | |

Clinical Justification (Circle all that apply)

Acute Care or Medical Restraint

AG Agitated
FALL Fall Risk High
INT Interfere w/ Treatment
W Wandering

Behavioral Health Restraint

CMB Combative/Hitting
DGR Danger to Self/Others

Time Limit for Restraint

Max ☐ 24 Hours Adult Acute Care
☐ 16 Hours
☐ 12 Hours
☐ 8 Hours
☐ Other _____

Max ☒ 4 Hours Adult Behavioral Health
☐ 2 Hours Ages 9-17 Years
☐ 1 Hour Ages 8 and Under

If Verbal Order, Read Back and Verified with Physician:
RN Signature: _____ /

RN Signature: _____

Physician Signature: _____

/ Order #: _____

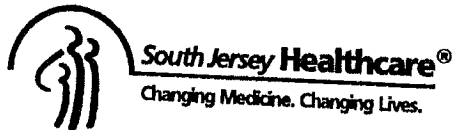
/ Time: 1645

PROGRESS NOTES

(Reason for Initiation or Continued Justification of Restraints)
Describe behavior and continued justification for restraint use

Pt became aggressive, physically abusive
and refused to cooperate

Physician Signature _____



Acct# 75282256MRN 941
 CATLETT, AMY
 DOB 02/06/1973 Sex F
 ATT DR: DIORIO, DOMINIC

11/21/2009
 Age 36Y

RESTRAINT ORDER FORM

Date Ordered: 11-21 Time Ordered: 1925
 Time Restraints Applied: 1925

Type of Restraint: Hand Mitt Soft Extremity Vest Body Net Seclusion Locked Velcro Safety Bed 4 Siderails
 Number of Extremities: (L) Hand (R) Hand (L) Arm (R) Arm (L) Leg (R) Leg
 Interventions Attempted (Circle all that apply)

| | | | |
|------------|--------------------------|-----------|-----------------------|
| C/S | Companion/Supervise | MED | Medication Review |
| <u>CM</u> | Comfort Measures | RE | Reposition |
| <u>ENV</u> | Modify Environment | PD | Postural Device |
| <u>RO</u> | Reality Orientation | S | Snacks |
| DIV | Diversion Activities | VI | 1:1 Verbal |
| CALL | Call Light in Reach | <u>PA</u> | Physical Reassessment |
| B/B | Bowel Bladder Regime | O | Other |
| MP | Move Pt Close to Station | FP | Fall Precautions |
| EX | Exercise | | |

Clinical Justification (Circle all that apply)

Acute Care or Medical Restraint

AG Agitated
FALL Fall Risk High
INT Interfere w/ Treatment
W Wandering

Behavioral Health Restraint

CMB Combative/Hitting
DGR Danger to Self/Others

Time Limit for Restraint

Max ☐ 24 Hours Adult Acute Care
☐ 16 Hours
☐ 12 Hours
☐ 8 Hours
☐ Other _____

Max ☒ 4 Hours Adult Behavioral Health
☐ 2 Hours Ages 9-17 Years
☐ 1 Hour Ages 8 and Under

If Verbal Order, Read Back and Verified with Physician: _____

RN Signature: _____ /

RN Signature: _____ / Order #: _____

Physician Signature: [Signature] / Time: 1928

PROGRESS NOTES

(Reason for Initiation or Continued Justification of Restraints)
 Describe behavior and continued justification for restraint use

*PT was risk to self and others & Bt nurse
 and fled department drug eval. - was restrained
 for safety and staff safety - not response
 to time of stress - appears calm & cooperated*

Physician Signature [Signature]

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RESTRAINT RECORD

☐ SJH Regional Medical Center ☐ SJH Elmer Hospital
☐ SJH Bridgeton Health Center

A REGISTERED NURSE WILL ASSESS AND REASSESS PATIENTS EVERY HOUR FOR PATIENTS BETWEEN THE AGES OF 5-17 YEARS; EVERY TWO HOURS FOR PATIENTS 18 YEARS AND OLDER.

[illegible]

Changing Medicine. Changing Lives.

☐ SJH Regional Medical Center ☐ SJH Elmer Hospital
☐ SJH Bridgeton Health Center

ORDER #:

Age 36Y

Circle all that apply

Circle all that apply

BGR Danger to self/others**

1 Finger fits under restraint

Circle Type: Soft / Waist Belt / Vest / ***Locked Velcro / Mitts / Safety Bed / 4 Sideralls
 Circle # of Extremities Restrained: 1 2 3 4

WA While Awake **TF** Tube Feeding
F Foley **NPO**
BR Bedrest

***Restrains for behavioral health require q 15 minute checks and face to face evaluation by MD within 1 hour of order.

| | | | |
|---------|---------------------|---------|---------------------|
| Initial | Signature and Title | Initial | Signature and Title |
| ms | M. M. Fortune | | |
| | | | |
| | | | |

Age 36Y

[illegible]

LARRY MAPOW, M.D.
DIRECTOR OF LABORATORIES

**DEPARTMENT OF PATHOLOGY
SOUTH JERSEY HEALTHCARE**

☐ SJH REGIONAL MEDICAL CENTER: 1505 WEST SHERMAN AVENUE, VINELAND, NJ 08360 (856) 641-7560
☐ SJH ELMER HOSPITAL: 501 WEST FRONT STREET, ELMER, NJ 08318-1090 (856) 363-1560
☐ SJH BRIDGETON HEALTH CENTER: 333 IRVING AVENUE, BRIDGETON, NJ 08302-2100 (856) 575-4560
☐ SJH VINELAND HEALTH CENTER: 1038 E. CHESTNUT AVENUE, VINELAND, NJ 08360 (856) 507-8588

Patient: CATLETT AMY Age: 36 YRS Sex: F Location: RER
 Patient Number: (00004)900038941 Physician: DIORIO DOMINIC A MD Admission Date: 21NOV09
 DOB: 02/06/1973 Discharge Date: 21NOV09

GENERAL CHEMISTRY

11/21/09
1842
SAT

| | | UNITS | REF RANGES |
|--------------------------------|-------|--------|------------|
| General Chemistry ----- | | | |
| GLUCOSE | 103 H | MG/DL | [60-100] |
| BUN | 11 | MG/DL | [5-22] |
| CREATININE | 0.9 | MG/DL | [0.6-1.3] |
| SODIUM | 141 | MEQ/L | [135-145] |
| POTASSIUM | 3.9 | MEQ/L | [3.6-5.0] |
| CHLORIDE | 108 | MEQ/L | [97-109] |
| CO2 | 27 | MEQ/L | [21-31] |
| ANION GAP | 6.0 | MEQ/L | [6.0-16.0] |
| BUN/CREA RATIO | 12 | | |
| OSMOLALITY | 281 | MOSM/K | |
| CALCIUM | 9.3 | MG/DL | [8.8-10.4] |
| GFR ESTIMATED | 75 | mL/MIN | |

GFR ESTIMATED

****ADULT REFERENCE RANGE: > OR = 60 mL/MIN/1.73m2****

** IF PATIENT IS AFRICAN-AMERICAN, MULTIPLY REPORTED RESULT BY 1.21 **

GFR ESTIMATED VALUES OF 61 AND HIGHER ARE TO BE INTERPRETED
AS >60 mL/min/1.73m2.

"For Drug dosing purposes, the NKDEP does NOT recommend using the MDRD Study Equation (eGFR) at this time because the clinical impact on drug dose adjustment has not been compared between current practice and the MDRD Study Equation. Pharmacists and Authorized Drug Prescribers should continue to use their current drug dosing methods (estimated creatinine clearance calculated by Cockcroft-Gault Equation)."

Footnotes
H = High

FINAL REPORT (PERMANENT)

Continued Next Page

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Patient Number: (00004)900038941 Physician: DIORIO DOMINIC A MD Admission Date: 21NOV09
DOB: 02/06/1973 Discharge Date: 21NOV09

T H E R A P E U T I C D R U G M O N I T O R I N G A N D T O X I C O L O G Y

11/21/09 11/21/09
1842 1925
SAT SAT

UNITS REF RANGES

Analgesics -----

ACETAMINOPHEN < 10.0 UG/ML [10.0-30.0]
ACETAMINOPHEN

THERAPEUTIC RANGE: 10-30 UG/ML
TOXIC RANGE: GREATER THAN 150 UG/ML

LD ACETAMIN UNK * HOURS
SALICYLATE < 4.0 MG/DL [4.0-30.0]
SALICYLATE

THERAPEUTIC RANGE: 1-60 MG/DL.
NOTE: 150-300 MG/DL MAY BE A THERAPEUTIC RANGE FOR RA.

LD SALICYLATE UNK * HOURS

Miscellaneous Drugs -----

ALCOHOL < 10.0 MG/DL
ALCOHOL

NORMAL: NEGATIVE
NEGATIVE: <10 MG/DL
TOXIC: GREATER THAN 250 MG/DL

| | | |
|---------------|------------|------------|
| PATH REV | DISCLAMR f | |
| AMP SC UA | NEGATIVE | [NEGATIVE] |
| BARB SC UA | NEGATIVE | [NEGATIVE] |
| BENZ SC UA | POSITIVE * | [NEGATIVE] |
| COCAINE SC UA | NEGATIVE | [NEGATIVE] |
| METD SC UA | NEGATIVE | [NEGATIVE] |
| OPI SC UA | NEGATIVE | [NEGATIVE] |
| PCP SC UA | NEGATIVE | [NEGATIVE] |
| THC SC UA | NEGATIVE | [NEGATIVE] |

PATH REV

THIS TEST PROVIDES PRELIMINARY UNCONFIRMED ANALYTICAL TEST RESULTS AND

Footnotes

* = Abnormal, f = Footnote

FINAL REPORT (PERMANENT)

Continued Next Page

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Patient: CATLETT AMY Age: 36 YRS Sex: F Location: RER
 Patient Number: (00004)900038941 Physician: DIORIO DOMINIC A MD Admission Date: 21NOV09
 DOB: 02/06/1973 Discharge Date: 21NOV09

 T H E R A P E U T I C D R U G M O N I T O R I N G A N D T O X I C O L O G Y

PATH REV SHOULD BE USED FOR MEDICAL (i.e., treatment) PURPOSES ONLY. UNCONFIRMED SCREENING RESULTS MUST NOT BE USED FOR NON-MEDICAL PURPOSES (e.g., employment testing, legal testing). A MORE SPECIFIC ALTERNATE CHEMICAL METHOD MUST BE USED IN ORDER TO OBTAIN A CONFIRMED ANALYTICAL RESULT. CLINICAL CONSIDERATION AND PROFESSIONAL JUDGEMENT SHOULD BE APPLIED TO ANY DRUG OF ABUSE TEST RESULT.

A FALSE POSITIVE RESULT MAY BE PRODUCED BY THE FOLLOWING COMPOUNDS:
 d,l-EPHEDRINE, PHENYLPROPANOLAMINE, PHENTERMINE, NYLIDRIN,
 PHENMETRAZINE, METHPHENIDATE, METHENTERMINE, LABETATEL, ISOXSUPRINE.
 THESE MEDICATIONS CAN BE IN OVER THE COUNTER DRUG PREPARATIONS.

| CUT-OFF VALUES: | BRIDGETON/RMC | ELMER |
|-----------------|---------------|-----------|
| U AMP | 1000ng/ml | 1000ng/ml |
| U BARB | 200ng/ml | 300ng/ml |
| U BENZ | 200ng/ml | 300ng/ml |
| U COC | 300ng/ml | 300ng/ml |
| U OPI | 2000ng/ml | 300ng/ml |
| U PCP | 25ng/ml | 25ng/ml |
| U THC | 50ng/ml | 50ng/ml |
| U METH | N/A | 1000ng/ml |
| U TCA | N/A | 1000ng/ml |
| U METHD | 300ng/ml | N/A |

 H E M A T O L O G Y

11/21/09
 1842
 SAT

----- Complete Blood Count -----

| | | UNITS | REF RANGES |
|------|--------|------------------|-------------|
| WBC | 12.9 H | X10 ³ | [4.0-11.0] |
| RBC | 4.27 | X10 ⁶ | [3.50-5.10] |
| HGB | 13.6 | G/DL | [11.0-15.2] |
| HCT | 40.6 | % | [32.0-45.0] |
| MCV | 95.0 | FL | [80.0-98.0] |
| MCH | 31.9 | PG | [27.6-34.5] |
| MCHC | 33.6 | G/DL | [33.0-36.0] |
| RDW | 12.8 | % | [11.3-15.0] |

Footnotes
 H = High

FINAL REPORT (PERMANENT)

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☐ SJH VINELAND HEALTH CENTER: 1038 E. CHESTNUT AVENUE, VINELAND, NJ 08360 (856) 507-8588

Patient: CATLETT AMY

Age: 36 YRS

Sex: F

Location: RER

Patient Number: (00004)900038941

Physician: DIORIO DOMINIC A MD

Admission Date: 21NOV09

DOB: 02/06/1973

Discharge Date: 21NOV09

HEMATOLOGY

11/21/09
1842
SAT

UNITS REF RANGES

Complete Blood Count -----

PLATELETS AUTO 250

X10³ [140-380]

Differential, Automated -----

NEUT % 81.7 H

% [40.0-74.0]

LYMPHS % 12.4 L

% [19.0-48.0]

MONO % 5.6

% [3.0-9.0]

EOS % .1

% [.0-7.0]

BASO % .2

% [.0-1.5]

Footnotes

L = Low, H = High

FINAL REPORT (PERMANENT)

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Page Number: 4

LARRY MAPOW, M.D.
DIRECTOR OF LABORATORIES

DEPARTMENT OF PATHOLOGY
SOUTH JERSEY HEALTHCARE

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Patient: CATLETT AMY Age: 36 YRS Sex: F Location: RER
 Patient Number: (00004)900038941 Physician: DIORIO DOMINIC A MD Admission Date: 21NOV09
 DOB: 02/06/1973 Discharge Date: 21NOV09

U R I N A L Y S I S

11/21/09
1925
SAT

UNITS REF RANGES

----- Macroscopic Analysis -----

| | | |
|-----------------|------------|------------|
| COLOR | YELLOW | [YELLOW] |
| CLARITY | CLOUDY * | [CLEAR] |
| GLUCOSE MG/DL | NEGATIVE | [NEGATIVE] |
| BILIRUBIN | NEGATIVE f | [NEGATIVE] |
| KETONES MG/DL | NEGATIVE | [NEGATIVE] |
| SPEC GRAVITY | 1.017 f | |
| U BLOOD | TRACE * | [NEGATIVE] |
| PH | 5.5 | [5.0-7.5] |
| PROTEIN MG/DL | 30MG/DL * | [NEGATIVE] |
| UROBILIN MG/DL | NORMAL | [0.1-0.2] |
| NITRATE | NEGATIVE | [NEGATIVE] |
| LEUKOCYTE ESTER | LARGE * | [NEGATIVE] |

BILIRUBIN

NOTE: FALSE POSITIVE URINE READINGS MAY BE PRODUCED BY MEDICATIONS
THAT TURN THE URINE RED OR ORANGE.

Bright red-orange color resulting from Pyridium may mask small
amounts of bilirubin when performing the Ictotest for bilirubin.
Chlorpromazine and Iodine may cause false positive or atypical
Ictotest results.

----- Microscopic Analysis -----

| | | |
|----------------|--------|------------|
| WBC/HPF | TNTC * | [0-5/HPF] |
| RBC/HPF | 5-10 * | [0-2/HPF] |
| BACTERIA | 4+ * | [NOT SEEN] |
| SQUAMOUS EPITH | TNTC * | [0-5/HPF] |

Footnotes

* = Abnormal, f = Footnote

SPEC GRAVITY

 NORMAL RANGES 1.005-1.030

FINAL REPORT (PERMANENT)

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Print Date/Time 11/24/09 2253

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Patient: CATLETT AMY

Age: 36 YRS

Sex: F

Location: RER

Patient Number: (00004)900038941

Physician: DIORIO DOMINIC A MD

Admission Date: 21NOV09

DOB: 02/06/1973

Discharge Date: 21NOV09

U R I N A L Y S I S

11/21/09
1925
SAT

UNITS REF RANGES

----- Macroscopic Analysis -----

URINE PREG

NEGATIVE

URINE PREG

THIS TEST IS STRICTLY FOR SCREENING PURPOSES,
CERTAIN CONDITIONS MAY LEAD TO INACCURATE RESULTS.
PLEASE CONTACT THE LABORATORY FOR MORE INFORMATION.

FINAL REPORT (PERMANENT)

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Print Date/Time 11/24/09 2253

Page Number: 6

LARRY MAPOW, M.D.
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DEPARTMENT OF PATHOLOGY
SOUTH JERSEY HEALTHCARE

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☐ SJH VINELAND HEALTH CENTER: 1038 E. CHESTNUT AVENUE, VINELAND, NJ 08360 (856) 507-8588

Patient: CATLETT AMY Age: 36 YRS Sex: F Location: RER
 Patient Number: (00004)900038941 Physician: DIORIO DOMINIC A MD Admission Date: 21NOV09
 DOB: 02/06/1973 Discharge Date: 21NOV09

 I M M U N O L O G Y A N D S E R O L O G Y

11/21/09
 1842
 SAT

UNITS REF RANGES

----- Hepatitis Serology -----

HEP B SURF AG NON REAC
 HEP C ANTIBODY NON REAC

[NON DETC]
 [NON REAC]

----- Miscellaneous Serologies -----

HIV suds method NEGATIVE
 11/21/09 1842

NEGATIVE FOR HIV-1 SUDS ANTIBODY TEST.
 THE SUDS HIV-1 TEST ALONE CANNOT BE USED TO DIAGNOSE HIV INFECTION.
 A NEGATIVE TEST RESULT AT ANY POINT IN THE INVESTIGATION OF THE INDIVIDUAL
 SUBJECT DOES NOT PRECLUDE THE POSSIBILITY OF EXPOSURE TO OR INFECTION WITH
 HIV-1.

END OF REPORT



Bridgeton Health Center - Emergency Department
333 Irving Ave. Bridgeton, NJ 08302
(856) 575-4500

Patient: AMY CATLETT, Date: 11/21/2009 Time: 23:28

Discharge Instructions

Learning Needs Identified: Illness

Primary Language: English

Barriers Identified: None

Intervention for Barriers to Learning: None

Teaching Methods Used: Printed patient instruction, Verbal Instruction

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. After you leave, you should **follow the instructions below.**

You were treated today by LAURA KASPER, DO.

THIS INFORMATION IS ABOUT YOUR FOLLOW UP CARE

Please return to the Emergency Department if your symptoms get worse. Return to your Psychiatrist, Dr. Friel

THIS INFORMATION IS ABOUT YOUR DIAGNOSIS

DEPRESSION/BEREAVEMENT

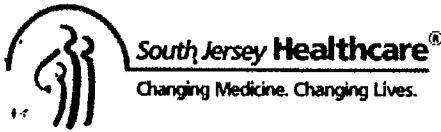
Depression is an illness that can affect every part of your life. Depression is different than the normal feelings of sadness or discouragement that everyone occasionally feels. The feelings that come with depression can last for weeks to months, even years. There are also physical changes that happen in the body when you are depressed.

Follow these instructions:

- Take your medicine regularly even if it doesn't seem to be making a difference.
- Eat food that is good for you, even if you are not hungry. Try fruits and vegetables, soups, and plenty of fluids.
- Get regular exercise. Go for a short walk outside or ride a stationary bike.
- Avoid alcohol or other recreational drugs. These can make your depression worse.
- Keep in touch with a friend or family member who is understanding about your depression. Call them once a day, if it's helpful, even if you don't have anything to say. Just being in contact with another person can be good for you.
- Keep appointments with your counselor or therapist even if you don't feel like going.
- Set small goals for yourself. Don't expect to complete major tasks while you are depressed.
- Remember depression is not a weakness. You can't make yourself better just by trying harder.
- Be patient with yourself. Recovering from depression takes time.
- Don't make any major decisions until you are feeling better.

If you are thinking about hurting yourself, do one of the following:

- Call your doctor or therapist
- Call 911
- Call a suicide prevention hotline found in your phone book's yellow pages
 - National Suicide Hotline 1-800-SUICIDE (784-2433)
 - Boys Town National Hotline 1-800-448-3000
 - Boys Town National Hotline for the deaf TDD 1-800-448-1833



Bridgeton Health Center - Emergency Department
333 Irving Ave. Bridgeton, NJ 08302
(856) 575-4500

Patient: AMY CATLETT, Date: 11/21/2009 Time: 23:28

- Covenant House Hotline 1-800-999-9999

Where can I get help to deal with my depression?

- Your family doctor
- A licensed counselor or therapist
- A psychologist or psychiatrist
- Your pastor, priest, or rabbi
- Community mental health centers
- Employee Assistance Programs through your workplace

Call your doctor if you:

- do not feel any better after trying the instructions listed under "Follow these instructions".
- have any new problems or concerns.

If you cannot reach your doctor, go to the nearest Emergency Department.

YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY. Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed. If you have problems that we have not discussed, **call or visit your doctor right away.** If you cannot reach your doctor, return to the Emergency Department.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician. I gave permission to fax notification of this visit to my follow up provider."

Refused to sign 2nd Will not pay
Never asked for this

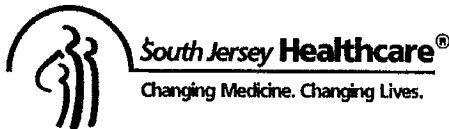
AMY CATLETT or Responsible Person

"AMY CATLETT or Responsible Person has received this information and tells me that all questions have been answered."

Prepared by: Beverly Foster

Reviewed by: LAURA KASPER, DO

South Jersey Healthcare is committed to Patient Satisfaction and we want to provide the best service possible.
If you have specific questions, concerns or compliments that you would like to discuss with us directly,
please feel free to call us at 856-641-8068.



Acct# 75282256MRN 941 11/21/2009
CATLETT, AMY
 DOB 02/06/1973 Sex F Age 36Y
 ATT DR: DIORIO, DOMINIC

Catlett, Amy
75282256

PATIENT TRANSFER FORM

Date 11/21/09 Time 2030

Transferring Physician Dr. William Martin

Receiving Hospital Bridgeton Hospital

Receiving Physician Laura Kasper

Report Given to: Shanna Groulx

Title RN

First & Last Name

First & Last Name

Diagnosis at time of Transfer: Suicide

Condition at time of Transfer: ☒ Stable ☐ Unstable ☒ Vital Signs: BP 140/90 Pulse 101 Resp 21 Temp 97.1

MRSA Yes ☐ No ☐ Pending ☐ N/A ☒ VRE Yes ☐ No ☐ Pending ☐ N/A ☒ TB Yes ☐ No ☐ Pending ☐ N/A ☒

Reason for Transfer: ☐ Tertiary Care ☐ Lack of Beds ☒ Services Availability ☐ Patient Request

☐ Other: Explain _____

Transfer Check List

ED Patients

- ED Treatment Record
- EMS Record

Yes No N/A
☒ ☐ ☐
☐ ☐ ☒

OBS Patients

- Mother & Baby's Cord Blood
- Mother & Baby's Medical Records

Yes No N/A
☐ ☐ ☒
☐ ☐ ☒

Medical Records

- Face Sheet
- H&P
- Phys. Progress Note
- Nursing Assessment
- Consultations
- Phys. Order Sheets
- Psychiatric Assessment
- Original Commitment Papers
- Medication Administration Record
- Medication Reconciliation Form

Yes No N/A
☒ ☐ ☐
☒ ☐ ☐
☒ ☐ ☐
☒ ☐ ☐
☐ ☐ ☒
☒ ☐ ☐
☐ ☐ ☒
☐ ☐ ☒
☒ ☐ ☐
☒ ☐ ☐

- Advance Directive/Living Will
- TPA Flow Sheet
- Laboratory Results
- EKGs
- X-Rays
- Ultra Sound
- CT
- Blood/Blood Products

Yes No N/A
☐ ☒ ☐
☐ ☐ ☒
☒ ☐ ☐
☐ ☐ ☒
☐ ☐ ☒
☐ ☐ ☒
☐ ☐ ☒
☐ ☐ ☒
☐ ☐ ☒

Psycho Social Status:

- Language Barrier
- Interpreter Needed
- Problems Identified
- See Nurses Notes
- See Social Service Notes
- Notified By Whom _____

Yes No N/A
☐ ☒ ☐
☐ ☒ ☐
☐ ☒ ☐
☐ ☒ ☐
☐ ☒ ☐

Other

- Consents Signed and Witnessed
- Family Notified:

Yes No N/A
☐ ☐ ☒
☒ ☐ ☐

Person Notified:

Name & Relationship _____

- Disposition of Valuables: ☐ With Patient ☐ Security ☒ Sent Home with: MRS

Print Name

Signature

Relationship

Mode of Transport: ☒ BLS Ambulance ☐ ALS Ambulance ☐ Helicopter ☐ Police ☐ Other: _____

Personnel Accompanying Patient in Transport: ☐ ACLS RN ☐ RN ☐ Resp. Therapist ☐ Physician ☐ EMT

☐ Other: _____ ☐ None Needed _____

Physician Signature

Transport Personnel: Name S. Gattis

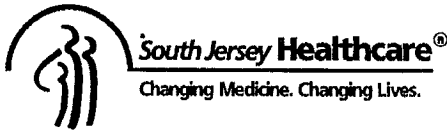
Department _____

Name S. Keyler

Department _____

Name _____

Department MRS



Acct# 75282256MRN 941 11/21/2009
 CATLETT, AMY
 DOB 02/06/1973 Sex F Age 36Y
 ATT DR: DIORIO, DOMINIC

CATLETT, Amy
 75282256

PATIENT TRANSFER FORM

MEDICAL RECORD

In accordance with Federal Law, you are notified that this hospital has the following legal responsibilities:

- This hospital must provide a medical screening exam to any person presenting to the emergency room to determine if the patient suffers from an emergency medical condition or from pregnancy with contractions present.
- In the event that an emergency medical condition or pregnancy with contractions is present, the hospital must provide within its capabilities such additional examination and treatment as may be required to stabilize the medical condition. In the event of pregnancy with contractions present, the hospital must deliver the baby and the placenta, EXCEPT in the case where the benefits of transfer outweigh the risks that may arise from or during labor.
- If the hospital or physician deems it in the best interest of the patient (or unborn child) to transfer the patient to another medical facility, the hospital requires that the physician execute a transfer certificate complying with the standards of the law and provide medically appropriate patient transfer.

Notice of Risks and Benefits

All transfers have inherent risks of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, limitations of equipment and personnel present in the vehicle, potential total diversion to other than intended facility because of deteriorating condition, unanticipated medical emergencies, worsening of medical condition, or death.

Additional possible risks include: _____

The benefits of transfer include: _____

Patient Consent/Refusal

I understand the hospital has offered to examine Amy Catlett (the patient) to determine if a medical emergency condition exists to provide necessary treatment to stabilize my condition and to provide a medically appropriate transfer to another facility and has explained the risks, benefits and options. I understand the risks, benefits and options. After considering the above information, I hereby:

☐ Consent to Transfer

☐ Refuse services and request transfer against medical advice. Reason: _____

☒ Refuse to consent to transfer. Reason: It doesn't feel she needs to go regardless of what comments made or posted on face book

Print Name _____ Signature _____ Date _____ Time _____

The patient is unable to sign because they are: ☐ a minor ☒ incompetent ☐ unconscious ☐ Other: _____

Consent was obtained from: _____

Print Name _____ Signature _____ Relationship _____
 Witness Signature Michelle Faler Date 11/21/09 Time 2030

Physician Certification

☒ Based on the information available to me at the time of transfer, the medical benefits expected from the provision of appropriate medical care at another facility outweigh the increased risk to the patient and/or unborn child from effecting the transfer.

☐ Patient/family has requested transfer to another facility for the above listed reasons. The benefits, risks and options to transfer have been explained to the patient/family who has voiced understanding.

Print Name R. Um... Signature _____ Date 11/21 Time 745

Signature of Person Completing Form Michelle Faler Date 11/21/09 Time 2030



South Jersey
Changing Media

Acct# 75282256 MRN 941
CATLETT, AMY
DOB 02/06/1973 Sex F
ATT DR: DIORIO, DOMINIC

11/21/2009

Age 36Y

MR# 285646455 Acct# 75282256 11/21/2009

CATLETT, AMY

DOB 06/06/1973

Sex F

Age 36Y

ADVANCE DIRECTIVE/ORGAN DONOR INTERVIEW FORM

SECTION A: ADMISSIONS OFFICE INFORMATION – For In/Outpatients 18 Years and Older

1. Does this patient have an Advance Directive/Living Will? ☐ YES ☒ NO
 - a. If YES to #1, do they have it with them? ☐ YES ☒ NO

If YES, I notified: _____ / _____
PCM, social services, PCC, SDS nurse, nursing supervisor (if 3-11 & 11-7) date/time
 - b. If NO to #1a, who will bring it to the admissions office? Name _____
 - c. When Advance Directive became available, I notified: _____
and sent to _____ unit. PCM, social services, PCC, SDS nurse, nursing supervisor (if 3-11 & 11-7)
2. If NO to #1:
 - a. Do they want information about Advance Directives? ☐ YES gave booklet ☒ NO
 - b. Do they want help completing an Advance Directive? ☐ YES ☒ NO

If YES, I notified _____ to follow-up with patient.
PCM, social services, PCC, SDS nurse, nursing supervisor (if 3-11 & 11-7)
3. Does patient have an organ donor card? ☐ YES ☒ NO
4. Copy of Advance Directive / Organ Donor Card sent to nursing unit. ☐ YES ☒ NO

I HAVE BEEN INFORMED THAT THE PRESENCE OR ABSENCE OF AN ADVANCE DIRECTIVE WILL IN NO WAY ALTER ANY CARE RENDERED TO ME AT SOUTH JERSEY HOSPITAL AND THAT POLICES ON ADVANCE DIRECTIVES ARE AVAILABLE FOR REVIEW UPON REQUEST.

Signature of patient, if unable to sign, have next of kin

Signature of registrar completing this section
and witness to patient signature

Time 1658

SECTION B: REVIEW OF ADVANCE DIRECTIVE – Completed by persons contacted by Admissions

1. Advance Directive reviewed for validity, appropriate witnesses, signature, date. ☐ YES ☒ NO
2. Document validity by recording: "verified", signature and date on copy of Adv. Directive. ☐ YES ☒ NO
3. Adv. Dir./Organ Donor Card placed behind Interview Form in Adv. Dir. Section of chart. ☐ YES ☒ NO
4. Advance Directive Sticker placed on chart cover. ☐ YES ☒ NO
5. Because a copy of the Advance Directive is not available at this time, a summary of directive as stated by patient is as follows: _____

6. Dr. _____ notified of presence of Advance Directive information ☐ YES ☒ NO
7. Section completed by: _____
PCM, social services, PCC, SDS nurse, nursing supervisor (if 3-11 & 11-7) date/time

SECTION C: EXISTING ADVANCE DIRECTIVE NOT VALID

1. Reviewed problems of invalid Advance Directive with patient. ☐ YES ☒ NO
2. Assisted patient in completing valid Advance Directive – if YES, go to Section B. ☐ YES ☒ NO
3. If problem not resolved, notify registration to change database. ☐ YES ☒ NO

SECTION D: CHANGING AN EXISTING ADVANCE DIRECTIVE

1. Review with patient the request to have the Advanced Directive changed. ☐ YES ☒ NO
2. Follow Section B if needed.
3. Section completed by: _____
Signature date/time

SECTION E: NO AVAILABLE ADVANCE DIRECTIVE/UNABLE TO CONFIRM EXISTENCE (Patient does not have decision-making capacity)

- ☐ 1. Patient unable to confirm existence of Advance Directive
- ☐ 2. No family member available/able to confirm existence of Advance Directive.

Signature _____

VINELAND EMERGENCY MEDICAL SERVICE

PATIENT REPORT

DISPATCH # 75092-09

RUN #

PATIENT'S NAME Callett Amy

WEIGHT lbs / kgs AGE 36 yrs / months

HOME ADDRESS 3137 Swan Dr VLD, NJ 08360

DATE OF BIRTH 2, 6, 73

INCIDENT LOCATION SAA

MALE ☐ FEMALE ☒ RACE Cav

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1 STATUS ON ARRIVAL <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Conscious <input type="checkbox"/> Unresponsive <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Alert only to Verbal <input type="checkbox"/> Alert only to Painful <input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Appropriate for Age <input type="checkbox"/> Agitated <input type="checkbox"/> Violent <input type="checkbox"/> Uncontrollable <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Respiratory Arrest <input type="checkbox"/> Witnessed <input type="checkbox"/> Unwitnessed <input type="checkbox"/> CPR Started-Time <input type="checkbox"/> By EMS <input type="checkbox"/> By EMS <input type="checkbox"/> By Lay Person <input type="checkbox"/> By Fire/Police <input type="checkbox"/> Other | | 2 PATIENT'S CHIEF COMPLAINT <input type="checkbox"/> N/A <input type="checkbox"/> Decreased Level of Consciousness <input type="checkbox"/> Numbness/Feeling <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Vision Loss/Disturbance <input type="checkbox"/> Nausea <input type="checkbox"/> Choking <input type="checkbox"/> Seizure Activity <input type="checkbox"/> Bleeding <input type="checkbox"/> Pain <input type="checkbox"/> Other | | 3 HISTORY OF INJURY <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Automobile <input type="checkbox"/> Firearm <input type="checkbox"/> Bike/Auto <input type="checkbox"/> Knife/Sm Object <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Machinery <input type="checkbox"/> Crushed <input type="checkbox"/> Motorcycle <input type="checkbox"/> Diving <input type="checkbox"/> Pedestrian/MVC <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Small Tool <input type="checkbox"/> Explosion/Fire <input type="checkbox"/> Sport <input type="checkbox"/> Fight/Violence <input type="checkbox"/> Truck <input type="checkbox"/> Other <input type="checkbox"/> Watercraft | | 4 PARTS INJURED <input type="checkbox"/> N/A <input type="checkbox"/> Abdomen <input type="checkbox"/> Forearm <input type="checkbox"/> Leg <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Head <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Thigh <input type="checkbox"/> Face <input type="checkbox"/> Other | |
| 5 OTHER OBSERVATIONS <input checked="" type="checkbox"/> N/A <input type="checkbox"/> None Site <input type="checkbox"/> Major Bleeding <input type="checkbox"/> Paralysis (new / old) <input type="checkbox"/> Weakness (new / old) <input type="checkbox"/> Suspected Fracture <input type="checkbox"/> Open Wounds <input type="checkbox"/> Other | | 6 LUNGS <input type="checkbox"/> N/A <input type="checkbox"/> Normal Air Exchange <input type="checkbox"/> Shallow Respirations <input type="checkbox"/> Deep Respirations <input type="checkbox"/> Respiratory Arrest LEVEL OF DISTRESS <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe ONSET <input type="checkbox"/> Acute <input type="checkbox"/> Gradual <input type="checkbox"/> Unknown SOUNDS <input type="checkbox"/> R <input type="checkbox"/> L Diminished <input type="checkbox"/> R <input type="checkbox"/> L Rhonchi <input type="checkbox"/> R <input type="checkbox"/> L Wheeze <input type="checkbox"/> R <input type="checkbox"/> L Rales | | 7 NATURE OF CALL <input type="checkbox"/> N/A (Medical Emergencies) <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Neurological/CVA <input type="checkbox"/> Respiratory Emergency <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> OB/GYN <input type="checkbox"/> Seizures <input type="checkbox"/> Cardiac-Other <input type="checkbox"/> Overdose <input type="checkbox"/> Transport-Emergency <input type="checkbox"/> Choking <input type="checkbox"/> Poisoning <input type="checkbox"/> Transport-Non Emergency <input type="checkbox"/> Diabetic <input type="checkbox"/> Psych/Behavior <input type="checkbox"/> Unconscious/Syncope <input type="checkbox"/> GI Complaint <input type="checkbox"/> Public Service <input type="checkbox"/> Unfounded <input type="checkbox"/> Medical Alarm <input type="checkbox"/> Respiratory Arrest <input type="checkbox"/> Weak/Malaise/Fever <input type="checkbox"/> Other | | (Trauma Emergencies) <input type="checkbox"/> Aircraft Crash <input type="checkbox"/> Electric Injury <input type="checkbox"/> Haz Mat <input type="checkbox"/> Assist Fire <input type="checkbox"/> Environmental-Cold <input type="checkbox"/> Machinery <input type="checkbox"/> Assist PD <input type="checkbox"/> Environmental-Heat <input type="checkbox"/> MVC <input type="checkbox"/> Bicycle Crash <input type="checkbox"/> Fall <input type="checkbox"/> Pedestrian/MVC <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Fire Call <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Burns <input type="checkbox"/> Firearm <input type="checkbox"/> Stabbing <input type="checkbox"/> Drowning/Near Drowning <input type="checkbox"/> Fractures <input type="checkbox"/> Watercraft Crash <input type="checkbox"/> Other | |
| 10 ONSET OF SYMPTOMS <input checked="" type="checkbox"/> N/A DATE / / TIME / / <input type="checkbox"/> UNKNOWN | | 12 PUPILS <input type="checkbox"/> N/A <input type="checkbox"/> Normal <input type="checkbox"/> R <input type="checkbox"/> L Dilated <input type="checkbox"/> R <input type="checkbox"/> L Constricted <input type="checkbox"/> Unequal <input type="checkbox"/> R <input type="checkbox"/> L Sluggish <input type="checkbox"/> R <input type="checkbox"/> L Non-Responsive | | 9 PAST MEDICAL HISTORY <input type="checkbox"/> N/A <input type="checkbox"/> Allergy <input type="checkbox"/> Epilepsy <input type="checkbox"/> Angina <input type="checkbox"/> Hypertension <input type="checkbox"/> Anxiety <input type="checkbox"/> MI / Heart Attack <input type="checkbox"/> Asthma <input type="checkbox"/> Pacemaker/Internal Delib <input type="checkbox"/> Behavioral <input type="checkbox"/> Patient Denied <input type="checkbox"/> Cancer <input type="checkbox"/> Psychiatric Illness <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Pulmonary Edema <input type="checkbox"/> Chronic Obstructive Pulmonary Distress <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Cerebral Vascular Accident / Trans Ischemic Attack <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Other | | | |
| 13 PATIENT MANAGEMENT <input type="checkbox"/> N/A <input type="checkbox"/> BLEEDING CONTROL <input type="checkbox"/> AUTO VENT <input type="checkbox"/> VACUUM SPLINTS <input type="checkbox"/> BURN TREATMENT <input type="checkbox"/> BAG VALVE MASK <input type="checkbox"/> ACTIVATED CHARCOAL <input type="checkbox"/> C-COLLAR <input type="checkbox"/> COMBITUBE / LMA <input type="checkbox"/> ASSIST WITH EPI-PEN <input type="checkbox"/> CID / BACKBOARD <input type="checkbox"/> DEFIBRILLATOR <input type="checkbox"/> ASSIST WITH INHALER <input type="checkbox"/> ICE PACK <input type="checkbox"/> HONORED A DNR <input type="checkbox"/> ASSIST WITH NTG X <input type="checkbox"/> KED <input type="checkbox"/> NASAL AIRWAY <input type="checkbox"/> IPECAC <input type="checkbox"/> MAST <input type="checkbox"/> INFLATED? <input type="checkbox"/> ORAL AIRWAY <input type="checkbox"/> OXYGEN / LPM <input type="checkbox"/> TRACTION SPLINT <input type="checkbox"/> SUCTION <input type="checkbox"/> NEONATAL DELIVERY | | 14 MEDICATIONS <input type="checkbox"/> N/A Lanex | | 15 ALLERGIES <input type="checkbox"/> N/A Patient Denied | | | |
| 16 DATE / TIME LOG Date 11/20/09 Unit Dispatched 11523 Unit Responded 11523 Arrived at Location 11530 Arrived MICU Departed Location 11534 Arrived at Hospital / LZ 11542 Available at Hospital / LZ 11600 Back in Assigned Area 11600 Responding From: Sta 2 | | 17 CREWS / VEHICLES / ADVANCED LIFE SUPPORT Vineland Emergency Medical Service Rig 1630 Crew Member Name, First and Last DiNunzio 2548 Crew Member Name, First and Last Watson 9083 Crew Member Name, First and Last ID MICU Responding <input type="checkbox"/> N/A <input type="checkbox"/> SNN <input type="checkbox"/> Too Far Out <input type="checkbox"/> Treated <input type="checkbox"/> Triage to BLS ID Air Ambulance <input type="checkbox"/> N/A <input type="checkbox"/> SNN <input type="checkbox"/> Too Far Out <input type="checkbox"/> Treated <input type="checkbox"/> Triage to BLS Grounded due to: | | 18 PATIENT DISPOSITION <input type="checkbox"/> N/A Transported to: BMC Disposition <input type="checkbox"/> Left ER AMA <input type="checkbox"/> Died in ER <input type="checkbox"/> DOA / ER <input type="checkbox"/> Dead at Scene Admitting DX Room # Treated and Released with DX 19 PROPERTY/ADVANCED DIRECTIVE <input type="checkbox"/> N/A Item(s) in Question: Turned Over To: Name and Position and or Relationship to Patient 20 EMERGENCY WARNING DEVICES USED <input type="checkbox"/> Not Used <input checked="" type="checkbox"/> Responding <input type="checkbox"/> On Location <input type="checkbox"/> To Hospital <input type="checkbox"/> Between Hospitals | | | |
| 21 COMMUNICATIONS WITH HOSPITAL <input type="checkbox"/> N/A Hospital BMC Physician / Nurse staff VIA: <input type="checkbox"/> HEAR <input type="checkbox"/> MICU <input type="checkbox"/> PD Communications <input type="checkbox"/> CC Communications <input checked="" type="checkbox"/> By Cell Phone <input type="checkbox"/> Other | | | | | | | |
| 22 EQUIPMENT LEFT ON / WITH PATIENT <input type="checkbox"/> N/A <input type="checkbox"/> None | | 23 PATIENT RESTRAINED FOR: <input type="checkbox"/> N/A | | | | | |

PREPARED BY SIGNATURE

DRIVERS SIGNATURE

REVIEWERS SIGNATURE

SUPERVISOR'S SIGNATURE OR INITIALS

PATIENT REPORT

PATIENT'S NAME Catlett, Amy

cc/None

Px/PT was walked to ambulance and became very uncooperative and agitated. PT refused to give any info other than name and DOB.

PT m/t to BMC w/o. PT care transferred to
staff (c-side) report given.

Meds / Zanex

Pmbhx / Anxiety

PREPARER'S SIGNATURE

SENIOR E.M.T.'S SIGNATURE _____

Screener Alexander, Louise**CUMBERLAND COUNTY GUIDANCE CENTER -- SCREENING CENTER
SCREENING ASSESSMENT & INTERVENTION RECORD**

Date: 11/21/09 Outreach: Yes ☐ No ☒ Interview site: BEA Chart Number: 0038941
 Client's Last Name: Catlett First: Arney
 Address: 3137 Swan Drive
 City: Yreland State: IN Zip Code: 08361
 Phone: (856) 692-0938 SSN#: refused to give Age: 36 D.O.B. 2/6/73
 Language: English Yes ☒ No ☐ [specify] _____ Hearing Impaired Yes ☐ No ☒ Translator required Yes ☐ No ☒
 Gender: Female ☒ Male ☐ Contact Person/Guardian: Marscha Zielinski Religious Affiliation: Catholic
 Race: Black ☐ Caucasian ☒ Hispanic ☐ Other ☐ (Please specify): _____
 Referral Source: (circle all that apply) Self Family Significant Other ICMS PACT Police Dept: BPD MPD VPD BSP PNSP
 Jail Court Nursing Home Assisted Living Mental Health Provider Shelter Other (list) _____

Client Accompanied By: MotherMarital Status: Single ☒ Married ☐ Life Partnership ☐ Divorced ☐ Separated ☐ Widowed ☐Current living situation: Alone ☐ Relatives/Family ☒ Other ☐ List: MotherChildren: No ☐ Yes ☐ Ages List: _____Veteran: Yes ☐ No ☒ Active Deployment Yes ☐ No ☒ Number of Tours of Duty ✓**Employment Status:**Employed ☒ Unemployed ☐ Public Assistance ☐ Retired ☐ Disabled ☐ List: _____Occupation: Lawyer Employer: Bae, Hays, KowalskiEducation: Highest grade completed: _____ Education Classification? Yes ☐ No ☐ Type: 19 + 8Legal Status: Pending/Present Criminal Charges Yes ☒ No ☐ List: (Describe) _____Past Criminal History: Yes ☐ No ☒ (Details of history) _____Probation/Parole Officer: Yes ☐ No ☒**Insurance Information & Authorizations**

[] Insurance [] No Insurance Medicaid # _____ Medicare # _____
 Subscriber: _____ Plan: _____ ID# _____
 Phone # _____ Insurance rep _____ Time of contact _____ # Days authorized _____
 Pre-Cert Yes ☐ No ☐ Inpt. _____ Partial _____ Crisis _____ Transport _____

| | | | | |
|------------------|------------------|------------|--------------|--------------------------|
| For Review Only: | Restraints _____ | Jail _____ | Police _____ | Return in 72 Hours _____ |
|------------------|------------------|------------|--------------|--------------------------|

Confidential Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for the purpose.

Client Name: Catlett Amy

Page 2

Medical History: (please check all that apply)Family Physician:Eating D/O: Anorexia Yes [] No [X] Bulimia Yes [] No [X] Pica Yes [] No [X] OtherHistory of Significant Head Trauma: Yes [] No [X] Onset age Seizures or other related problems: Yes [] No [X]

Describe:

Significant Medical History/Treatment: Yes [] No [X] (medical problems, surgeries)Allergies: Yes [] No [X] List:Medications: Yes [X] No [] List: Xanax 1mg BID, Traxodon 300mg
T.H.SER Interventions: (Check all that Apply)

Meds Given: (list/time given):

No medication givenRestraints: (time / reason)Labs: ✓ (type / results) urine Preg @ 0.05 @ Bony, Valproic Acid
47.0 @ WBC, 12.9 @ Neut 81.7 @ Lymphs 12.4 @ Ferritin 103 @
T B/P R PStudies: X Rays

Results

CAT Scan

Results

EKG

Results

Presenting Problem: (Current stressors, precipitating factors, current symptoms/behaviors and duration of problem)

this 36yo A/W/ female presented to the ER accompanied
by her Mother transfer from RMC for psychiatric
evaluation. Pt report that she had ^{been} "Torn back
and said she was going to close her account she
would like to know when a rock or be put in a
Coma for a year." She told Police advised at her
door saying she was suicidal and they were taking
to the hospital. When I got there I refused to let them
get my blood. They took my jewelry from me and my
clothes. Finally they put me in 4 points I bit a nurse
when they were trying me down. When I refuse penicillin
I had been to pay." I am not suicidal never been suicidal
I have been wearing a cross around my neck since I was 6
a small child.

Client Name: Cattell, Amy

Page 3

Psychosocial History/Supports: Pt is a practicing Lawyer but has
b/t 11 mos ago around this time she has a supportive
mother and many friends

Mental Status Examination:**Orientation:** Time Yes ☒ No ☐Place Yes ☒ No ☐Person Yes ☒ No ☐**General Appearance:** (Describe physical characteristics, apparent age, peculiarity of dress, grooming & personal hygiene)

Hospital gown, look younger than stated age
Hygiene good

Behavior, Activity & Response to Interview: Gestures Tics Grimacing Mannerisms Reluctance Engaging GuardedFearful Angry Agitated Threatening Provocative Dramatic Impulsive Calm Cooperative UncooperativeEye contact: Good ☒ Fair ☐ Poor ☐

Other/Describe: _____

Speech: (Rate, Volume, Productivity, Pitch, Clarity) Normal Pressured Rambling Slow Soft Loud Mute Slurred

Echolalia Describe: _____

Mood/Affect: (Circle all that apply & describe below) **Mood:** Happy Calm Worried Anxious Depressed Sad FrightenedAngry **Affect:** Blunted Flat Broad Labile Alert Tense Frowning Suspicious Crying Bright Laughing Smiling**Affect/Facial Expression Appropriate to Mood:** Yes ☐ No ☐ (Explain any incongruence above)Delusions Yes ☐ No ☒Hallucinations Yes ☐ No ☒Command Hallucinations Yes ☐ No ☒

Describe: _____

Thought Processes: Normal Relevance Rationality Organized Looseness of Assoc. Tangential Flight of Ideas Other: _____**Memory:** Immediate: Intact Impaired Recent: Intact Impaired Remote: Intact or Impaired Describe below: _____**Attention Span/Concentration:** Good ☒ Fair ☐ Poor ☐ Describe any deficits: _____

Client's Name: Catlett, Amy

Page 4

Sleep: No disturbance ☐ Increased ☐ Decreased ☐ Difficulty Falling Asleep ☐ Early Awakening ☐
 Nightmares (Describe any abnormalities):

4-6 hrs sleep

Appetite/ Eating Disorders: No disturbance ☐ Increased ☐ Decreased ☐ Binging ☐ Purging ☐ Weight Gain ☐ Weight Loss ☐

Explain any abnormality: Eat once a day

Insight & Judgment: Insight: Good ☐ Fair ☒ Impaired ☐ Judgement: Good ☐ Fair ☒ Impaired ☐ Describe: _____

Suicide/Other Directed Harm Assessment

Suicide Ideation: Yes ☐ No ☒ Describe Denies S/I & H# - Pt states "Phase 1 never been suicidal"

Frequency of Thoughts: _____ per day _____ per week _____ per month

Duration of Thoughts: _____ seconds _____ minutes _____ hours

Suicide Plan: Yes ☐ No ☒ **Other Harm** Yes ☐ No ☐

When: _____

Where: _____

How: _____

Specific Preparation: Yes ☐ No ☒ Describe: (i.e. hoarding pills, writing suicide/homicide notes) _____Suicide Rehearsal: Yes ☐ No ☒ Describe _____Access to Means: Yes ☐ No ☒ Describe _____Degree of Lethality as Rated by Clinician Low ☒ Medium ☐ High ☐

Are guns readily accessible to client (home, work etc.): Yes ☐ No ☒ If response is "yes," provide details of plan to eliminate primary access to guns.

Impulsive Behaviors: Yes ☐ No ☒ Current _____

Past Impulsivity: _____

Client Name: Catell Amy

Page 5

Stressors:

- 1) Loss Event: (anniversary date, death, status, financial, other) Recently lost boyfriend
Approximately 11 mo ago
- 2) Relationship Problems: None
- 3) Interpersonal Isolation: None
- 4) Health Concerns: None
- 5) Legal Concerns: None

*** The following section is to be completed by the client with the assistance of the clinician.**

I have thoughts of ending my life? (circle the best answer) Never Rarely Sometimes Frequently Always

Rate and fill out each item below according to how you feel right now.

Rank each category in their order of significance on a 1 -5 scale: (1 = most significant to 5 = least significant)

Risk of Self Harm

| | |
|------|---|
| Rank | 1) Rate Psychological Pain (hurt, misery or mental anguish, not stress, not physical pain): Low Pain 1 2 3 4 5 High Pain What I find most painful is: _____ |
| Rank | 2) Rate Stress (your general feeling of being pressured or overwhelmed): Low Stress 1 2 3 4 5 High Stress What I find most stressful is: _____ |
| Rank | 3) Rate Agitation (emotional urgency and feeling that you need to take action; not irritation, not annoyance): Low Agitation 1 2 3 4 5 High Agitation I feel the most need to take action when: _____ |
| Rank | 4) Rate Hopelessness (expectation that things will not get better regardless of your efforts): Low Hopelessness 1 2 3 4 5 High Hopelessness I feel most hopeless about: _____ |
| Rank | 5) Rate Self-Hate (your general feeling of disliking yourself; having no self-esteem, no self respect): Low Self-Hate 1 2 3 4 5 High Self-Hate What I hate most about myself is: _____ |
| N/A | 6) RATE OVERALL RISK OF SUICIDE: Extremely Low Risk (will not kill self) 1 2 3 4 5 Extremely High Risk (will kill self) |

Client Name:

Catlett, Amy

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How much is being suicidal related to thoughts and feelings about yourself? Not at all 1 2 3 4 5 CompletelyHow much is being suicidal related to thoughts and feelings about others? Not at all 1 2 3 4 5 Completely**List your reasons for wanting to live and reasons for wanting to die. Rank in order of significance.**

(1 = most significant to 5 = least significant)

| Rank | REASON FOR LIVING | Rank | REASON FOR DYING |
|------|-------------------|------|------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please circle the most accurate answer to the following questions.

I wish to live to the following extent: Not at all: 1 2 3 4 5 :Very much

I wish to die to the following extent: Not at all: 1 2 3 4 5 :Very much

The one thing that would help me to no longer feel suicidal would be: _____

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Other Current Self-Injurious Behaviors: Yes ☐ No ☒ Describe _____**Previous Suicidal or Self-Injurious Behaviors:** Yes ☐ No ☒ (Provide specific details) _____**Danger To Self -- Not Suicidal:** Yes ☐ No ☒ Describe _____

Client Name:

Catlett, Amy

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Risk of Harm to Others**Answers to Likert scale questions are provided by the client and recorded by the clinician**

I have thoughts of hurting someone else? (circle best answer) Never Rarely Sometimes Frequently Always

Rank each category in their order of significance on a 1 -5 scale: (1 = most significant to 5 = least significant)

| | |
|------|--|
| Rank | 7) Rate level of Fear (your general sense or feeling of being endangered or threatened by someone or something): Low Fear 1 2 3 4 5 High Fear What I am most fearful of is: _____ |
| Rank | 8) Rate level of Anger (annoyance, resentment, rage or blame directed at another person, people in general, agency, institution, situation): Low anger 1 2 3 4 5 High anger The situation or person that causes me to be most angry is: _____ |
| Rank | 9) Rate level of Hate (your general feeling of disliking someone or something): Low Hate 1 2 3 4 5 High Hate What I hate most is: _____ |
| Rank | 10) Rate Agitation (feeling of urgency and sense of need to take action regarding your specific anger, hate or fears): Low Agitation 1 2 3 4 5 High Agitation I feel the most need to take action when: _____ |
| Rank | 11) RATE OVERALL RISK OF HURTING or HARMING SOMEONE ELSE: Extremely Low (will not harm anyone) 1 2 3 4 5 Extremely High (will take action to harm someone) |

Current Indicators of Dangerousness to Others? Yes ___ No ✓ (Statements of ideation or plan, actions taken) _____**History of Violence to Others?** Yes ___ No ✓ Explain _____**Destructive To Property?** Yes ___ No ✓ (Provide details of ideation, plan, actions) _____

Client Name: Catlett, Amy

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Psychiatric History: Currently in treatment Yes ☒ No ☐ Explain/List Provider: Dr. Huel**Compliant With Treatment:** Yes ☒ No ☐ **Medication:** Yes ☒ No ☐ Explain: Xanax, Prozac**Past Treatment Providers:** None**Psychiatric Advanced Directives:** Yes ☐ No ☒ Explain: _____**Screening Center Contact Within Past 30 Days?** Yes ☐ No ☒**Disch. From Psych Hosp Within Past 30 Days?** Yes ☐ No ☒ **Which Hospital?** _____**Previous Psychiatric Hospitalizations:**

| <input type="checkbox"/> BMHU Date | <input type="checkbox"/> STCF Date | <input type="checkbox"/> Hampton Date | <input type="checkbox"/> Ancora Date | <input type="checkbox"/> BCCIS Date | <input type="checkbox"/> Shoreline Date | <input type="checkbox"/> Other Date |
|---------------------------------------|---------------------------------------|--|---|--|--|--|
| / / | / / | / / | / / | / / | / / | / / |
| / / | / / | / / | / / | / / | / / | / / |
| / / | / / | / / | / / | / / | / / | / / |
| / / | / / | / / | / / | / / | / / | / / |

Family History of Mental Illness: _____**Screening for Substance Abuse:**

Failure to meet obligations (social, interpersonal, occupational)? ☐ Yes ☒ No
 Others expressed concern about your use? ☐ Yes ☒ No
 Stopped taking prescribed medication in order to use? ☐ Yes ☒ No
 Used to change your mood /self medicate? ☐ Yes ☒ No
 Ever use to help you wake up or go to sleep? ☐ Yes ☒ No
 After using ever told yourself "I will never do that again" ☐ Yes ☒ No
 History of withdrawal seizures? ☐ Yes ☒ No
 Substance of choice? _____

Under the influence have done things out of the ordinary? ☐ Yes ☒ No
 Ever used more than you intended? ☐ Yes ☒ No
 Currently abusing drugs or alcohol? ☐ Yes ☒ No
 History of blackouts? ☐ Yes ☒ No
 Do you need more to get high? ☐ Yes ☒ No
 Can you stop using whenever you want once you start? ☐ Yes ☒ No
 Can you accurately predict the amount that you will use? ☐ Yes ☒ No
 Substance used most often? _____

Current or Previous Substance Abuse Treatment ? Yes ☐ No ☒ Specify treatment & list dates or timeframes _____**Current Use: (Substance, Amount, Frequency of Use, Method, Duration of Use, Last Use)**

Alcohol: _____
 Marijuana: _____
 Heroin: _____
 Cocaine: _____
 Others: _____

Client's Last Name: CatlettFirst: Anna

Chart #: _____

ADDENDUM NOTESCollateral9A

| Date/Time | Discussion / Comments / Staff signature |
|-----------------|--|
| 11-21-9 2236 | <p>Clt. Mother states someone saw a comment saw a comment on Face book because concerned → called the state police. Mother Marsha Zichinski states clt has been depressed since her fiancee died 11 mos. ago. Clt is seeing Mr. Treel and did see a grief counselor. Clt living with her Mother and her Mother knows Anna is depressed but she is not suicidal. Clt's Mom states her clt completed grief counseling at a Nazareth Church. discussed clt & her boys → Attorney Rose and her friends. Both state clt is depressed but slowly making progress. She also went to Washington DC (laughed & enjoyed herself). They agree Clt is acting inappropriate 20 days by not being herself. Yesterday police knocked on her door, took took</p> |

[] NOT APPLICABLE LOS: _____ TIME START: _____ AM/PM TIME END: _____ AM/PM

[illegible]

[] NOT APPLICABLE LOS: _____ TIME START: _____ AM/PM TIME END: _____ AM/PM

Collateral

9. B

[illegible]

[] NOT APPLICABLE LOS: _____ TIME START: _____ AM/PM TIME END: _____ AM/PM

Client Name: Catlett, Amy

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Current Symptoms of Withdrawal? Yes ☐ No ☒ (Describe) _____

History of Withdrawal? Yes ☐ No ☒ (Describe) _____

Additional Information re: Substance Abuse: None

Domestic Violence / Sexual Assault: Client is the victim? Yes ☐ No ☒ Client is the offender? Yes ☐ No ☒ (specify details)

1997 from ex boyfriend

Collateral Information: Document all efforts to contact family/service providers whether or not successful.

Family / Significant Other: (include name & info provided) phone ☐ in-person ☐ unavailable ☐ not applicable ☐

Collateral per Page 9A & B

Treatment Providers: (name & information provided) phone ☐ in-person ☐ unavailable ☒ not applicable ☐ Explain:

Dr. Trice

CCGC Contacts (CMHC5 Check): None ☒ Closed ☐ Open ☐ Crisis Only ☐ List Dates: _____

Other: (i.e. police, boarding home, other social service agencies) phone ☐ in-person ☐ unavailable ☐ not applicable ☐

Previous Records Obtained & Reviewed? Yes ☐ No ☒ (Summary of any additional significant info from previous records. If records are not available, document all efforts to obtain them) None

Client Name: Catlett, Amy

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Current Identified Needs/Problem Formulation: Circle all that apply & elaborateMood Disorder Psychosis Depression Danger to Self Danger to Others Housing Financial Anxiety Substance Abuse

Sleep Disorder Legal/Criminal Medical/Somatic Unable to Adhere to Treatment Transportation Marital/Relationship/Family

Other (explain)/Elaborate: _____

_____**Client Strengths and Protective Factors:** Strong Support System Intact Family Stable Employment Future Goals

Any Deterrents To Self Harm (children pets religion)

Other(explain)/Elaborate: _____

_____**Consultations**Psychiatrist (name): Dr. Parikh ☒ phone ☐ face ☐ telepsychiatry time _____Discussion/Recommendations: He can go home with family and follow-up w Dr. ParikhSupervisor's name: _____ ☒ N/A ☐ phone ☐ face Time _____

Discussion/Recommendations: _____

E.R. Physician name: Dr. Kasper ☐ N/A ☐ phone ☒ face Time _____Discussion/Recommendations: Medication cleared for crisisOther Clinical Consultation (name): _____ ☒ N/A ☐ phone ☐ face Time _____

Discussion/Recommendations: _____

Diagnostic Impression:Depressed DSM - CODE 62.82 AXIS IDefensive DSM - CODE _____ AXIS II

DSM - CODE _____ AXIS _____

No Medical Problems ICD 9 - CODE _____ AXIS III _____AXIS IV _____ AXIS: GAF 40Lost B/P sudden death 11 Mo ago
He had grief counseling before starting with
Dr. Parikh. To help with this loss.

Client's Name

Catherine Arroyo

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Interventions Provided / Disposition Plan

Crisis Stabilization Techniques: Document all interventions directed at the provision of support, control & structure e.g. client safety search, ensure safe environment during crisis contact, de-escalation, analysis of problem & engagement of problem solving skills, techniques to decrease perturbation, engagement of social support system, negotiation of safety maintenance & development of contingency plan

Maintained in a safe environment for Pt
Refused all services - would not sign
any paper - "I should not be here" "I not
paying or paying for this."

Client / Family Education: (Review of discharge/treatment plan, other topics covered & client / family response)

Refused - Pt did agree to call Dr. Truel on
Monday. Since we would only get the
answering service.

Admission to ECES: Further assessment necessary ☐ Crisis stabilization ☐ Other ☐ (elaborate reason for admission)

n/a

Discharge to Home/Community: Condition improved ☐ Needs can be appropriately & safely met without hospitalization ☐
Psych inpatient not indicated ☒ No evidence of danger to self, others or property at this time ☒
Refused inpatient & does not meet commitment criteria ☒ Signed out AMA, risks explained ☐ Other (explain) ☐

Dr. Truel is off & Dr. Truel
keep scheduled appointments
1/4/10

Client Name: Cattell, Amy

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Out-Pt Treatment Plan:Outpatient Referral: Appt scheduled (specify clinic, date, time) n/APatient to arrange appt (specify) n/AWill continue with current treatment & provider (specify) Dr. Stuel

Referral to other agency and/or specialized services (specify), include any services offered but rejected by client

n/A

Client and/or family response to treatment plan, level of participation, understanding and willingness to follow through

Screening follow-up/linkage required? Yes ___ No ☒**Psychiatric Inpatient Admission:**Hospital / Facility n/A

Specify rationale & reason for ruling out less restrictive alternate treatment.

Less restrictive options are: Not available ___ Not appropriate ___ Specify: _____

(Include all travel time, paper work, collateral contacts, etc.)

LOF: 06 LOS: 02 TIME START: 10³⁰ AM / PM TIME END: 12⁰⁰ AM / PM DATE: 11/21/09

SCREENER SIGNATURE /DEGREE/TITLE:

Louise Alexander MEd CS

SCREENER NAME /DEGREE/TITLE (PRINT):

LOUISE ALEXANDER MEd CS